| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | | |
|--|----------------------|---|--------------|---|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 01 | COMPLETED | |
| | | 155139 | B. WING | | 02/11/2013 | |
| NAME OF E | PROVIDER OR SUPPLIEF | | STREET | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | KOVIDEK OK SUFFLIEF | | 2233 W | / JEFFERSON ST | | |
| | WOODS VILLAGE | | KOKO | MO, IN 46901 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID PREFIX | PROVIDER'S PLAN OF CORRECTION | | |
| PREFIX | ` | ACH DEFICIENCY MUST BE PRECEDED BY FULL | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE | |
| K0000 | | | | | | |
| | A Life Safety Co | ode Recertification and | K0000 | February 28, 2013 Ms. K | im | |
| | | Survey was conducted by | | Rhoades, Director Indiana Sta | l l | |
| | | e Department of Health in | | Department of Health 2 North | | |
| | | 42 CFR 483.70(a). | | Meridian St. Indianapolis, | | |
| | accordance with | 72 CIR 703.70(a). | | Indiana 46204 Dear Ms. Rhoades: Please accept thi | | |
| | Survey Date: 02 | 0/11/12 | | 2567 Plan of Correction for the | | |
| | Survey Date. Uz | u 1 1 / 1 J | | Life Safety Code Survey endir | | |
| | Facility Name | 000064 | | 2-11-13, as our Letter of Credi | ble | |
| | Facility Number | | | Allegation. Thank you for your | | |
| | Provider Numbe | | | time in reviewing our plan of | | |
| | AIM Number: 1 | 100288770 | | correction and please call with any questions. Sincerely, | | |
| | | | | Cathy S. Greene Executive | | |
| | - | p Komsiski, Life Safety | | Director North Woods Village | | |
| | Code Specialist | | | | | |
| | | | | The creation and submission of | | |
| | At this Life Safe | ty Code survey, North | | this plan of correction does no constitute an admission by this | | |
| | Woods Village v | was found not in | | provider of any; conclusion se | l l | |
| | compliance with | Requirements for | | forth in the statement of | ` | |
| | Participation in 1 | Medicare/Medicaid, 42 | | deficiencies or of any violation | of | |
| | * | 3.70(a), Life Safety from | | regulation. This provider | | |
| | | 00 edition of the National | | respectfully request that the 29 | | |
| | | Association (NFPA) 101, | | plan of correction be considered the letter of credible allegation | l l | |
| | | e (LSC), Chapter 19, | | and request a post certification | | |
| | <u>-</u> | • | | review on or after 3-13-13. | ` | |
| | _ | Care Occupancies and | | | | |
| | 410 IAC 16.2. | | | | | |
| | This tree of a C | a ailita a sana a datamanina a data | | | | |
| | | acility was determined to | | | | |
| | • • • • | 00) construction and was | | | | |
| | | . The facility has a fire | | | | |
| | _ | th smoke detection in the | | | | |
| | corridors and spa | aces open to the corridors. | | | | |
| | The resident roo | ms have battery powered | | | | |
| | smoke detection | . The facility has a | | | | |
| | | | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

TITLE

(X6) DATE

PRINTED: 03/01/2013
FORM APPROVED
OMB NO. 0938-0391

| | OF CORRECTION IDENTIFICATION | ON NUMBER: | (X2) MULTIPLE CO A. BUILDING | 01 | COMPLETED |
|--------------------------|---|---|---------------------------------|---|----------------------|
| | 155139 | | A. BUILDING B. WING | | 02/11/2013 |
| | PROVIDER OR SUPPLIER WOODS VILLAGE | | 2233 W | ADDRESS, CITY, STATE, ZIP CODE JEFFERSON ST 10, IN 46901 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF I (EACH DEFICIENCY MUST BE PR REGULATORY OR LSC IDENTIFYI | ECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | capacity of 164 and had a ce the time of this survey. | nsus of 148 at | | | |
| | All areas where the residents customary access were sprin areas which provide facility sprinklered except for the tw garages for facility storage a Quality Review by Robert B Safety Code Specialist-Medion 02/18/13. The facility was found not in with the aforementioned regirequirements as evidenced by following: | klered. All services were to detached and a shed. ooher, Life cal Surveyor compliance ulatory | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet

Page 2 of 25

PRINTED: 03/01/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155139 | | A. BUI | LDING | ONSTRUCTION 01 | (X3) DATE (COMPL 02/11/ | ETED | |
|--|--|--|--------|---------------------|--|------|----------------------------|
| | ROVIDER OR SUPPLIER | | B. WIN | STREET A | ADDRESS, CITY, STATE, ZIP CODE JEFFERSON ST MO, IN 46901 | | |
| NORTH | WOODS VILLAGE | | | KOKON | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| K0025 SS=E | least a one half haccordance with a terminate at an at protected by fire-riglass panels and of two separate con each floor. Da duct penetrations ducted heating, viconditioning system 19.1.6.3, 19.1.6.4. Based on observing facility failed to barrier walls were the one half hour the smoke barrier requires the passimaterials such as protected, so the penetrating item shall be filled with maintaining the samoke barrier or approved device purpose. This deaffect 24 residen and 36 residents halls as well | re constructed to provide at our fire resistance rating in 3.3. Smoke barriers may rium wall. Windows are rated glazing or by wired steel frames. A minimum ompartments are provided mpers are not required in of smoke barriers in fully entilating, and air ems. 19.3.7.3, 19.3.7.5, ration and interview, the ensure 2 of 9 smoke re protected to maintain after resistance rating of r. LSC Section 8.3.6.1 rage of building service apipe, cable or wire be space between the and the smoke barrier than the smoke b | K00 | 025 | February 28, 2013 Ms. Kim Rhoades, Director Indiana State Department of Health 2 North Meridian St. Indianapolis, Indiana 46204 Dear Ms. Rhoades: Please accept this 2567 Plan Correction for the Life Safety Code Survey ending 2-11-13, our Letter of Credible Allegation | as | 03/13/2013 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet Page 3 of 25

PRINTED: 03/01/2013
FORM APPROVED
OMB NO. 0938-0391

| | OF CORRECTION | IDENTIFICATION NUMBER: 155139 | A. BUII | LDING | 01 | COMPL 02/11/ | ETED |
|--------------------------|---|---|---|---------------------|---|-----------------|----------------------------|
| NAME OF P | PROVIDER OR SUPPLIER | | B. WIN | STREET A | ADDRESS, CITY, STATE, ZIP CODE | 02/11/ | 2010 |
| NORTH \ | WOODS VILLAGE | | 2233 W JEFFERSON ST KOKOMO, IN 46901 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | (X5) COMPLETION DATE |
| | smoke barrier was gap on the left six conditioning supthe smoke barrier the wall. Also, the diameter opening penetrating the wall. Also, the north smoke Furthermore at the smoke barrier was one half inch diameter opening remaining one in opening was not material. Based at 2:59 p.m. with Supervisor, it was north and south states and second floor. | e second story, north all above the ceiling a six inch by four inch de of a heating/air ply line which penetrated r to the right of center of there was a one inch g around a pipe vall on the far left side of | | | Thank you for your time in reviewing our plan of correction and please call with any questions. Sincerely, Cathy S. Greene Executive Director North Woods Village | n | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet

Page 4 of 25

PRINTED: 03/01/2013 FORM APPROVED OMB NO. 0938-0391

| | | IDENTIFICATION NUMBER: 155139 | A. BUILDING B. WING | 01 | COMPLETED 02/11/2013 | |
|--------------------------|---------------------|---|---|--|----------------------|--|
| NAME OF P | ROVIDER OR SUPPLIER | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NORTH \ | WOODS VILLAGE | | 2233 W JEFFERSON ST KOKOMO, IN 46901 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | |
| | | | | The creation and submission of the plan of correction does not constitute an admission by this provider of a conclusion set forth in the statem of deficiencies or of any violation regulation. This provider respectfully request that the 2567 plan of correction be considered the letter of credible allegation and request a post K025 It is the practice of this provider to ensure that the ceiling smoke barriers are protected to maintain one half hour fire resistance rating meet LSC requirements. What corrective actions will be accomplished for those residents. | tute any; ent of e | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet Page 5 of 25

| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO | 01 | (X3) DATE SURVEY COMPLETED |
|--------------------------|----------------------------------|---|---------------------|---|--|
| | | 155139 | B. WING | | 02/11/2013 |
| | PROVIDER OR SUPPLIE | | 2233 W | ADDRESS, CITY, STATE, ZIP CODE / JEFFERSON ST MO, IN 46901 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | | | | found to have been affected by deficient practice? | the |
| | | | | *Residents in the facility have the potential to be affected by the alleged deficient practice. *Area requiring a smoke barrier a protected to maintain the one ha hour fire resistance rating have be assessed and appropriate areas have been repaired with fire caul meet the LSC requirement on 2-12-13 by Maintenance Supervition Will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? *Residents in the facility have the potential to be affected by the alleged deficient practice. *The facility has placed appropriate ciling smoke barriers in identified area in second story north and so identified areas with fire caulk on 2-12-13 by Maintenance Supervition will make to ensure deficient practice does not recur? *Identified areas have had appropriate ceiling smoke barrier repaired with fire caulk. *Reviewed other potential areas have repaired these areas as needed with fire caulk to meet LS | are If been Ik to Sor. Dont Es ate Id Douth Sor Bes At TS and |
| | | | | Standards on 2-12-13 by Maintenance Supervisor How will the corrective action b | e |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet

Page 6 of 25

PRINTED: 03/01/2013 FORM APPROVED OMB NO. 0938-0391

| AND PLAN (| T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155139 | (X2) MULTIPLE CO A. BUILDING B. WING STREET A | ONSTRUCTION 01 ADDRESS, CITY, STATE, ZIP CODE | (X3) DATE SURVEY COMPLETED 02/11/2013 |
|--------------------------|------------------------------------|--|---|---|---------------------------------------|
| | ROVIDER OR SUPPLIEI | K | 2233 W | / JEFFERSON ST MO, IN 46901 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | ON (X5) DE PRIATE COMPLETION DATE |
| | | | | monitored to ensure the defi practice will not recur? | |
| | | | | *monthly preventive maintena schedule and CQI "Life Safety Review" tool will be used wee monthly x 3 and quarterly up to months to monitor so deficien practice does not recur by Maintenance Director. *Maintenance Director is resp for compliance, results will be reported to QA committee Completion Date: 3-13-13 certification review on or af 3-13-13. | y okly x 4, to 6 t |
| | | | | | |
| | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet

Page 7 of 25

| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | ONSTRUCTION | (X3) DATE SURVEY | |
|-----------|---------------------|--|----------------------------|------|---|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DINC | 01 | COMPLI | ETED |
| | | 155139 | B. WIN | | | 02/11/2013 | |
| | | | D. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | JEFFERSON ST | | |
| NORTH \ | WOODS VILLAGE | | | | /O, IN 46901 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PREFIX | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| K0029 | NFPA 101 | 205 074410400 | | | | | |
| SS=E | LIFE SAFETY CO | | | | | | |
| | | ed construction (with ¾ ors) or an approved | | | | | |
| | | inguishing system in | | | | | |
| | | 8.4.1 and/or 19.3.5.4 | | | | | |
| | protects hazardoi | us areas. When the | | | | | |
| | | itic fire extinguishing | | | | | |
| | | used, the areas are | | | | | |
| | | ther spaces by smoke s and doors. Doors are | | | | | |
| | | on-rated or field-applied | | | | | |
| | _ | that do not exceed 48 | | | | | |
| | | ottom of the door are | | | | | |
| | permitted. 19.3 | 3.2.1 | | | | | |
| | Based on observ | ation and interview, the | K00 | 29 | | | 03/13/2013 |
| | facility failed to | ensure 1 of 2 doors | | | K29 It is the practice of this provid | ler | |
| | leading to hazar | dous areas on Service | | | to ensure that one hour fire rated construction 3/4 fire rated doors ha | ive | |
| | hall such as roon | ns with combustible | | | self closures to protect hazardous | | |
| | items was provid | led with self closing | | | areas. | | |
| | - | ould cause the door to | | | | | |
| | automatically clo | ose and latch into the | | | | | |
| | _ | s deficient practice | | | What corrective actions will be | | |
| | | ts in the Activity room | | | accomplished for those resident | | |
| | | ervice hall as well as | | | found to have been affected by t deficient practice? | ne | |
| | visitors and staff | | | | adilicioni praesioo i | | |
| | visitors and start | • | | | | | |
| | Findings include | | | | AD-ald-out-loads 6 99 to 9 | | |
| | r manigs meiude | • | | | *Residents in the facility have the potential to be affected by the | | |
| | Dagad are alease | ation on 02/11/12 -t | | | alleged deficient practice. | | |
| | | ation on 02/11/13 at | | | , | | |
| | 12:55 p.m. with | | | | *Dietary Area requiring self closur | e | |
| | • | Kitchen Storage room | | | on door has had appropriate self closure installed on 2-13-13 by | | |
| | _ | on Service hall contained | | | Maintenance Supervisor. | | |
| | • | boxes inside the room | | | 3,000,000 | | |
| | which was greate | er than fifty square feet in | | | | | |
| | size and it did no | ot have a self closing | | | How will you identify other | | |
| | device on the co | rridor door. Based on | | | residents having the potential to | 1 | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet Page 8 of 25

PRINTED: 03/01/2013 FORM APPROVED OMB NO. 0938-0391

| | TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER: 155139 | (X2) MULTIPLE CO A. BUILDING B. WING | 01 | (X3) DATE SURVEY COMPLETED 02/11/2013 | | |
|--------------------------|--|--|---|---------------------------------------|--|--|
| | ROVIDER OR SUPPLIER WOODS VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | DATE | | |
| | interview on 02/11/13 at 12:58 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned door | | be affected by the same deficier practice and what corrective action will be taken? | nt | | |
| | leading into the Storage room containing combustible items was not equipped with a self closing device on the door. 3.1-19(b) | | *All residents have the potential taffected by the alleged deficient practice. *The facility has installed a self closure to door in dietary closet a identified on 2-13-13 by Maintena Supervisor. | ırea | | |
| | | | What measures will be put into place or what systematic chang you will make to ensure deficier practice does not recur? | | | |
| | | | *All hazardous area doors have to assessed to ensure all have appropriate self closures per Life Safety Code (LSC) by maintenar Supervisor by 2-15-13 *Maintenance Supervisor will mowith monthly preventive maintenar schedule. | nitor | | |
| | | | How will the corrective action be monitored to ensure the deficient practice will not recur? | nt | | |
| | | | *monthly preventive maintenance | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet

Page 9 of 25

PRINTED: 03/01/2013 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | IDENTIFICATION NUMBER: 155139 | A. BUILDING B. WING | 01 | (X3) DATE COMPL 02/11 | LETED |
|--------------------------|----------------------|---|---------------------|--|------------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | <u>I</u> | STREET . 2233 W | ADDRESS, CITY, STATE, ZIP CODE V JEFFERSON ST MO, IN 46901 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY) | | (X5) COMPLETION DATE |
| | | | | schedule and CQI "Life Safet Review" tool will be used wee monthly x 3 and quarterly up months to monitor so deficien practice does not recur. | kly x 4, to 6 | |
| | | | | *Maintenance Director is resp for compliance, results will be reported to QA committee | | |
| | | | | Completion Date: 3-13-13 | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet

Page 10 of 25

| STATEMEN | IT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | SURVEY | |
|-----------|---------------------|------------------------------|---|--------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | 01 | COMPL | ETED |
| | | 155139 | B. WIN | | | 02/11/ | 2013 |
| | | | B. WIIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | JEFFERSON ST | | |
| NODTU V | WOODS VILLAGE | | | | MO, IN 46901 | | |
| NORTH | | | | KOKOK | 70, 111 40901 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | ΓE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| K0047 | NFPA 101 | | | | | | |
| SS=E | LIFE SAFETY CO | DDE STANDARD | | | | | |
| | | al signs are displayed in | | | | | |
| | accordance with | | | | | | |
| | | nation also served by the | | | | | |
| | emergency lightin | | | | | | |
| | | ations and interview, the | K00 |)47 | | | 03/13/2013 |
| | facility failed to | provide directional signs | | | K47 It is the practice of this provid | | |
| | | lischarge means of egress. | | | to ensure that exit and directional signs are displayed in accordance | | |
| | | res the exit discharge | | | with section 7.10 with continuous | • | |
| | • | I and marked to make | | | illumination also served by the | | |
| | • | | | | emergency lighting system. | | |
| | | n of egress to a public | | | | | |
| | _ | ent practice could affect | | | | | |
| | 6 residents in Mo | oving Forward dining | | | What corrective actions will be | | |
| | room on Admini | strative hall, first floor | | | accomplished for those resident | s | |
| | including visitors | s and staff who may not | | | found to have been affected by t | | |
| | _ | exists at the east end of | | | deficient practice? | | |
| | | | | | | | |
| | the Administrativ | ve nan. | | | | | |
| | | | | | l | | |
| | Findings include | : | | | *Residents in the facility have the | | |
| | | | | | potential to be affected by the alleged deficient practice. | | |
| | Based on observa | ation on 02/11/13 at 2:27 | | | anaged denoising practice. | | |
| | | aintenance Supervisor, | | | *Exit sign in administrative area w | as | |
| | • | kit signs posted at the east | | | installed 2-14-13 by Maintenance | | |
| | | | | | Supervisor. | | |
| | | nistrative hall showing | | | | | |
| | 1 2 | discharge to the public | | | | | |
| | way. Based on i | nterview on 02/11/13 at | | | How will you identify other | | |
| | 2:30 p.m. it was | acknowledged by the | | | residents having the potential to | | |
| | _ | pervisor, the primary exit | | | be affected by the same deficien | | |
| | | From the Administrative | | | practice and what corrective | | |
| | | | | | action will be taken? | | |
| | | ious without exit signs | | | | | |
| | posted. | | | | | | |
| | | | | | *Residents in the facility have the | | |
| | 3.1-19(b) | | | | potential to be affected by the | | |
| | | | | | alleged deficient practice. | | |
| | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet Page 11 of 25

PRINTED: 03/01/2013 FORM APPROVED OMB NO. 0938-0391

| | | IDENTIFICATION NUMBER: 155139 | A. BUILDING B. WING | 01 | COMPLETED 02/11/2013 |
|--------------------------|---------------------|---|----------------------|---|----------------------|
| | ROVIDER OR SUPPLIER | | 2233 W | ADDRESS, CITY, STATE, ZIP CODE JEFFERSON ST MO, IN 46901 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | (X5) COMPLETION DATE |
| | | | | *Exit sign in administrative area winstalled 2-14-13 by Maintenance Supervisor. | |
| | | | | What measures will be put into place or what systematic change you will make to ensure deficien practice does not recur. | |
| | | | | *Exit sign in administrative area w installed 2-14-13 by Maintenance Supervisor. | |
| | | | | *All doors were checked by Maintenance Supervisor for appropriate exit signage. | |
| | | | | *Door signage will be monitored for per monthly Preventive Maintenant Schedule. | |
| | | | | How will the corrective action be monitored to ensure the deficier practice will not recur i.e., what quality assurance program will be put into place? | nt |
| | | | | *monthly preventive maintenance schedule and CQI "Life Safety Review" tool will be used weekly a monthly x 3 and quarterly up to 6 months to monitor so deficient | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet Page 12 of 25

PRINTED: 03/01/2013 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | IDENTIFICATION NUMBER: 155139 | (X2) MULTIPLE CO A. BUILDING B. WING | 01 | COMPLE 02/11/2 | TED |
|--------------------------|----------------------|---|--|---|-------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | 2233 W | ADDRESS, CITY, STATE, ZIP CODE / JEFFERSON ST | 3 | |
| NORTH | WOODS VILLAGE | | KOKON | MO, IN 46901 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | TION D BE OPRIATE | (X5) COMPLETION DATE |
| | | | | practice does not recur. | | |
| | | | | *Maintenance Director is response for compliance, results will be reported to QA committee | | |
| | | | | | | |
| | | | | Completion Date: 3-13-13 | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet

Page 13 of 25

| | | | | (X3) DATE SU | | | |
|-----------|---------------------|---|--|--------------|--|------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | ING | 01 | COMPLET | ED |
| | | 155139 | B. WING | | | 02/11/20 | 013 |
| NAME OF D | ROVIDER OR SUPPLIER | | <u> </u> | STREET A | DDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | ROVIDER OR SUFFLIER | | | 2233 W | JEFFERSON ST | | |
| NORTH \ | WOODS VILLAGE | | | KOKOM | IO, IN 46901 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | Œ (| COMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| K0056 | NFPA 101 | | | | | | |
| SS=E | LIFE SAFETY CO | matic sprinkler system, it is | | | | | |
| | | dance with NFPA 13, | | | | | |
| | | nstallation of Sprinkler | | | | | |
| | | de complete coverage for | | | | | |
| | • | building. The system is | | | | | |
| | | ed in accordance with | | | | | |
| | | rd for the Inspection, ntenance of Water-Based | | | | | |
| | Fire Protection Sy | | | | | | |
| | | e is a reliable, adequate | | | | | |
| | | he system. Required | | | | | |
| | | are equipped with water | | | | | |
| | - | switches, which are cted to the building fire | | | | | |
| | - | 19.3.5 | | | | | |
| | - | ation and interview, the | K005 | 6 | | | 03/13/2013 |
| | | ensure a complete | | | K056 | | |
| | _ | ler system was installed | | | | | |
| | • | th NFPA 13, 1999 | | | | | |
| | | ion of Sprinkler Systems, | | | It is the practice of this provider to | | |
| | | lete coverage for all | | | ensure that complete automatic | | |
| | | uilding. NFPA 13, | | | sprinkler system is installed in accordance with LSC standards. | | |
| | • | "Minimum Distance | | | accordance with EGC standards. | | |
| | | | | | | | |
| | • | ers", states sprinklers | | | Miles to a mark the section of the s | | |
| | - | ot less than 6 feet on | | | What corrective actions will be accomplished for those resident: | s | |
| | | on, LSC 19.1.1.4.5 | | | found to have been affected by the | | |
| | • | enovations, alterations, | | | deficient practice? | | |
| | | or repairs shall not | | | | | |
| | _ | below the level that | | | | | |
| | | ed. This deficient | | | *Residents in the facility have the | | |
| | • | fect 5 residents in the | | | potential to be affected by the | | |
| | | ning room as well as | | | alleged deficient practice. | | |
| | staff or visitors n | ear the kitchen. | | | *All areas identified have been | | |
| | | | | | reviewed and quotes for installation | | |
| | Findings include | : | | | of appropriate sprinklers have been obtained and will be installed | en | |
| | | | | | Obtained and will be installed | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet Page 14 of 25

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE C | ONSTRUCTION | (X3) DATE SURVEY | |
|--|---------------------|------------------------------|-----------------|--|------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 01 | COMPLETED | |
| | | 155139 | B. WING | | 02/11/2013 | |
| NAME OF D | ROVIDER OR SUPPLIER | | STREET | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | 2233 V | V JEFFERSON ST | | |
| NORTH \ | WOODS VILLAGE | | KOKO | MO, IN 46901 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE | |
| | | | | properly ASAP per PIPE sprinkler | | |
| | Based on observ | ration on 02/11/13 at | | company. | | |
| | 12:40 p.m. with | the Maintenance | | | | |
| | • | west side of the Kitchen | | | | |
| | - | er unit had two sprinkler | | How will you identify other | | |
| | | the ceiling which were | | residents having the potential to | | |
| | | • | | be affected by the same deficient practice and what corrective | ıτ | |
| | • | Based on interview on | | action will be taken? | | |
| | 02/11/13 at 12:4 | • | | | | |
| | Maintenance Su | | | | | |
| | _ | ne two sprinkler heads in | | *Residents in the facility have the | | |
| | • | meet the six foot | | potential to be affected by the | | |
| | separation requi | rement. | | alleged deficient practice. | | |
| | 2.1.10(1) | | | *All areas identified have been | | |
| | 3.1-19(b) | | | reviewed and quotes for installation | | |
| | | | | of appropriate sprinklers have be | en | |
| | | | | obtained and will be installed properly ASAP per PIPE sprinkle | r | |
| | | | | company. | | |
| | | | | | | |
| | | | | | | |
| | | | | What measures will be put into | | |
| | | | | place or what systematic change | | |
| | | | | you will make to ensure deficien | t | |
| | | | | practice does not recur. | | |
| | | | | | | |
| | | | | | | |
| | | | | *All sprinklers have been checked ensure proper footage between | d to | |
| | | | | sprinkler heads per LSC standard | ds | |
| | | | | by Maintenance Supervisor. | | |
| | | | | *\\/!!! he mes : !!- : ! : | | |
| | | | | *Will be monitored per monthly Preventive Maintenance Schedul | e. | |
| | | | | | | |
| | | | | | | |
| | | | | How will the corrective action be | | |
| | | | | monitored to ensure the deficier | | |
| | | | | The state of the s | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet Page 15 of 25

PRINTED: 03/01/2013 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | IDENTIFICATION NUMBER: 155139 | (X2) MULTIPLE CC A. BUILDING B. WING | 01 | COMPLETED 02/11/2013 |
|--------------------------|----------------------|---|--|---|----------------------|
| | PROVIDER OR SUPPLIER | | 2233 W | ADDRESS, CITY, STATE, ZIP CODE / JEFFERSON ST MO, IN 46901 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | COMPLETION DATE |
| | | | | practice will not recur i.e., wha quality assurance program wil put into place? | |
| | | | | *monthly preventive maintenant schedule and CQI "Life Safety Review" tool will be used weekl monthly x 3 and quarterly up to months to monitor so deficient practice does not recur. | y x 4, 6 |
| | | | | *Maintenance Director is resported to QA committee | nsible |
| | | | | Completion Date: 3-13-13 | |
| | | | | | |
| | | | | | |
| | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet

Page 16 of 25

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE S | SURVEY |
|--|--|--|-------------------|------------|---|---------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 01 | COMPL | ETED |
| | | 155139 | A. BUII B. WIN | | | 02/11/ | 2013 |
| | | | b. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | JEFFERSON ST | | |
| NODTH \ | WOODS VILLAGE | | | | MO, IN 46901 | | |
| | | | _ | RORON | | | |
| (X4) ID | | FATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | E | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| K0062 SS=E | continuously mair condition and are periodically. 19 NFPA 25, 9.7.5 1. Based on obset the facility failed sprinkler heads of were free of corredition, 2-2.1.1 r shall be replaced corroded, damag improper orienta | DDE STANDARD tic sprinkler systems are ntained in reliable operating inspected and tested 1.7.6, 4.6.12, NFPA 13, ervation and interview, to ensure 2 of 11 observed in the Kitchen osion. NFPA 25, 1998 equires any sprinkler which is painted, ed, loaded, or in the tion. This deficient fect the 5 residents in the | K00 | 062 | K62 It is the practice of this provid to ensure that required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. What corrective actions will be | y | 03/13/2013 |
| | • | ning room as well as | | | accomplished for those resident found to have been affected by to deficient practice. | | |
| | 12:30 p.m. with a Supervisor, the to located in the Diwere covered with the sprinkler ape interview on 02/the Maintenance confirmed the spthe Kitchen dish 3.1-19(b) | wo sprinkler heads sh room of the Kitchen th corrosion around both | | | *Residents in the facility have the potential to be affected by the alleged deficient practice. *All areas identified have been reviewed and quotes for installation of appropriate sprinklers have been obtained and will be installed properly ASAP per PIPE sprinkler company. *The sprinkler pipe with cable wire wrapped on it in Room #240 has been cable wire removed by Maintenant Supervisor | en e e nad | |
| | | | 1 | | How will you identify other | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet Page 17 of 25

| | TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155139 | (X2) MULTIPLE CO A. BUILDING B. WING | 01 | (X3) DATE SURVEY COMPLETED 02/11/2013 |
|--------------------------|--|--|---|---------------------------------------|
| | PROVIDER OR SUPPLIER WOODS VILLAGE | 2233 W | ADDRESS, CITY, STATE, ZIP CODE JUSTERSON ST JO, IN 46901 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | the facility failed to ensure 1 of 1 automatic sprinkler systems was maintained in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 | | residents having the potential to be affected by the same deficien practice and what corrective action will be taken? | |
| | requires sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice | | *Residents in the facility have the potential to be affected by the alleged deficient practice. | |
| | could affect 28 residents on second floor, east hall as well as visitors and staff. | | *All areas with sprinkler heads ha been checked for proper operatin condition by Maintenance Supervisor. | |
| | Based on observation on 02/11/13 at 2:45 p.m. with the Maintenance Supervisor, a ten foot section of a two inch diameter | | *All sprinkler pipes have been checked for cable wire per Maintenance Supervisor. | |
| | sprinkler pipe had cable wire wrapped around the sprinkler pipe in resident room # 240. Based on interview on 02/11/13 at 2:48 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned sprinkler pipe in room # | | What measures will be put into place or what systematic change you will make to ensure deficient practice does not recur? | I |
| | 240 had a cable wire wrapped around the pipe for support. 3.1-19(b) | | *All areas identified have been reviewed and quotes for installation of appropriate sprinklers have be obtained and will be installed properly ASAP per PIPE sprinkle company | en |
| | | | *All sprinkler pipes have been checked for cable wire per Maintenance Supervisor. *Will be monitored through preventive maintenance monthly check and quarterly fire alarm system check. | |
| | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet

Page 18 of 25

PRINTED: 03/01/2013 FORM APPROVED OMB NO. 0938-0391

| AND PLAN (| OF CORRECTION ROVIDER OR SUPPLIEF | IDENTIFICATION NUMBER: 155139 | A. BUILDING B. WING STREET | 01 ADDRESS, CITY, STATE, ZIP CODE | COMPLETED 02/11/2013 |
|--------------------------|------------------------------------|--|----------------------------|--|----------------------|
| | VOODS VILLAGE | | | / JEFFERSON ST //O, IN 46901 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | (X5) COMPLETION DATE |
| | | | | How will the corrective action be monitored to ensure the deficie practice will not recur i.e., what quality assurance program will put into place? | ent : |
| | | | | *monthly preventive maintenanc schedule and CQI "Life Safety Review" tool will be used weekly monthly x 3 and quarterly up to 6 months to monitor so deficient practice does not recur. | / × 4, |
| | | | | *Maintenance Director is respon for compliance, results will be reported to QA committee | sible |
| | | | | Completion Date: 3-13-13 | |
| | | | | | |
| | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet Page 19 of 25

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155139 | | | | LDING | ONSTRUCTION 01 | (X3) DATE S COMPL 02/11/ | ETED |
|---|--|---|-----------|---------------------|--|---------------------------------------|----------------------------|
| NAME OF PROVIDE | | | p. (1.1.) | 2233 W | ADDRESS, CITY, STATE, ZIP CODE / JEFFERSON ST MO, IN 46901 | | |
| TAG RI | EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| SS=E LIFE Pen prot Bass facil wall prov sect desi shal oper smo coul seco in th Find Bass p.m. smo inch whice wall inter the I ackr wall duct dam | etrations of sected in accorded on observative failed to despenetrated with a second for the provided ming or duct part of the provided for the provided for the second floor, as we event of a second floor with the Marke damper we diameter super penetrated for the second floor for the second floor for the second floor for the second floor | once barriers by ducts are dance with 8.3.6. Intion and interview, the ensure 1 of 9 smoke by ventilation ducts was smoke damper. LSC 101 ates an approved damper at the passage of smoke for each air transfer benetration of a required this deficient practice esidents on north hall, well as visitors and staff fire emergency. Ation on 02/11/13 at 3:07 intenance Supervisor, a as not installed in a six oply ventilation duct the north smoke barrier and floor. Based on 11/13 at 3:10 p.m. with Supervisor, it was e north smoke barrier benetrated by ventilating t protected with a smoke | KO | 104 | K104 It is the practice of this provide ensure that the penetrations of smoke barriers by ducts are protected in accordance with 8.3 meet LSC requirements. What corrective actions will be accomplished for those resident found to have been affected by deficient practice? *Residents in the facility have the potential to be affected by the alleged deficient practice. *Area requiring a smoke wall penetrated by ventilation ducts or second floor, the temporary ducts were removed, dry wall installed repaired with fire caulk to meet the LSC requirement on 2-12-13 by Maintenance Supervisor. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? *Residents in the facility have the potential to be affected by the alleged deficient practice. | ts the | 03/13/2013 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet

Page 20 of 25

PRINTED: 03/01/2013 FORM APPROVED OMB NO. 0938-0391

| | T OF DEFICIENCIES OF CORRECTION | IDENTIFICATION NUMBER: 155139 | (X2) MULTIPLE CO A. BUILDING B. WING | 01 | COMPLETED 02/11/2013 |
|--------------------------|-------------------------------------|---|--|--|----------------------|
| | ROVIDER OR SUPPLIE VOODS VILLAGE | R | 2233 W | ADDRESS, CITY, STATE, ZIP CODE / JEFFERSON ST MO, IN 46901 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | (X5) COMPLETION DATE |
| | | | | *Area requiring a smoke wall penetrated by ventilation ducts of second floor, the temporary ductive were removed, dry wall installed repaired with fire caulk to meet LSC requirement on 2-12-13 by Maintenance Supervisor. * All other smoke walls checked ensure to meet the LSC requirer on 2-12-13 by Maintenance Supervisor. | ts I and the to |
| | | | | What measures will be put into place or what systematic chang you will make to ensure deficie practice does not recur? | ges |
| | | | | *Area requiring a smoke wall penetrated by ventilation ducts of second floor, the temporary duct were removed, dry wall installed repaired with fire caulk to meet LSC requirement on 2-12-13 by Maintenance Supervisor. * All other smoke walls checked | ts l and the |
| | | | | ensure to meet the LSC requirer on 2-12-13 by Maintenance Supervisor. *Will be monitored through preventive maintenance monthly check per Maintenance Supervisor. | , |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet

Page 21 of 25

PRINTED: 03/01/2013 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | IDENTIFICATION NUMBER: 155139 | A. BUILDING B. WING | 01 | COMPLETED 02/11/2013 |
|--------------------------|--------------------------------------|---|---------------------|---|----------------------|
| | ROVIDER OR SUPPLIER WOODS VILLAGE | | 2233 W | ADDRESS, CITY, STATE, ZIP CODE / JEFFERSON ST MO, IN 46901 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | | | | How will the corrective action be monitored to ensure the deficient practice will not recur? | |
| | | | | *monthly preventive maintenance schedule and CQI "Life Safety Review" tool will be used weekly monthly x 3 and quarterly up to 6 months to monitor so deficient practice does not recur by Maintenance Director. *Maintenance Director is respons for compliance, results will be reported to QA committee Completion Date: 3-13-13 | x 4, |
| | | | | | |
| | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet Page 22 of 25

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE C A. BUILDING | ONSTRUCTION 01 | (X3) DATE SURVEY COMPLETED | |
|--|---|--|---------------------|--|--|
| | | 155139 | B. WING | | 02/11/2013 |
| | PROVIDER OR SUPPLIER | . | STREET 2233 V | ADDRESS, CITY, STATE, ZIP CODE V JEFFERSON ST MO, IN 46901 | 1 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| K0143 SS=E | NFPA 101 LIFE SAFETY CO Transferring of ox (a) separated from wherein patients treated by a separated from wherein patients treated by a separated from wherein patients treated by a separate floor fire-resisting in the impermitted in accounts that transferring in smoking in the impermitted in accounts facility failed to storage rooms, who occurs had a sign oxygen transfer floor, east hall, could affect 4 re floor, east hall, east floor, east | DDE STANDARD kygen is: m any portion of a facility are housed, examined, or a facility vertically ventilated, has ceramic or concrete sted with signs indicating soccurring, and that a facility and that a facility and the facility and th | K0143 | K143 It is the practice of this provide to ensure transferring oxygen is a area posted with signs indicating transferring is occurring. What corrective actions will be accomplished for those resident found to have been affected by deficient practice. *Residents in the facility have the potential to be affected by the alleged deficient practice. *Transferring oxygen sign was puplace immediately and inservice staff that would transfer oxygen view on 2-19-13 by Staff Development Coordinator. | o3/13/2013 to take the object of the control of th |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet

Page 23 of 25

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE (| | (X3) DATE SURVEY | |
|--|---------------------|------------------------------|-------------|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 01 | COMPLETED |
| | | 155139 | B. WING | | 02/11/2013 |
| NAME OF P | ROVIDER OR SUPPLIER | | | ADDRESS, CITY, STATE, ZIP CODE | |
| | | | | N JEFFERSON ST | |
| NORTH | WOODS VILLAGE | | KOKC | MO, IN 46901 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| | _ | n posted on or near the | | | |
| | , , , | room door indicating the | | How will you identify other | |
| | | en was being conducted at | | residents having the potential to | |
| | | on interview on 02/11/13 | | be affected by the same deficient practice and what corrective | nt |
| | • | th the Maintenance | | action will be taken? | |
| | Supervisor and N | - | | | |
| | _ | ney did not know posting | | | |
| | | red, or if the facility had | | *Residents in the facility have the | |
| | one available. | | | potential to be affected by the | |
| | 2.1.10(1) | | | alleged deficient practice. | |
| | 3.1-19(b) | | | *Transferring oxygen sign was p | ut in |
| | | | | place immediately and inservice | |
| | | | | staff that would transfer oxygen vigiven on 2-19-13 by Staff | vas |
| | | | | Development Coordinator. | |
| | | | | *Davinda will be assessed at a deily | 2 |
| | | | | *Rounds will be completed daily weeks periodically thereafter for | x 2 |
| | | | | correct usage of sign, by Directo | r of |
| | | | | Nursing and/or designee | |
| | | | | | |
| | | | | | |
| | | | | What measures will be put into | |
| | | | | place or what systematic chang you will make to ensure deficie | |
| | | | | practice does not recur? | " |
| | | | | | |
| | | | | | |
| | | | | *Identified fire alarm control pane | |
| | | | | area has had automatic smoke | |
| | | | | detector installed. | |
| | | | | *Transferring oxygen sign was p | ut in |
| | | | | place immediately and inservice | to |
| | | | | staff that would transfer oxygen vigiven on 2-19-13 by Staff | was |
| | | | | Development Coordinator. | |
| | | | | | |
| | | | | *Rounds will be completed daily | x 2 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet

Page 24 of 25

PRINTED: 03/01/2013 FORM APPROVED OMB NO. 0938-0391

| | | IDENTIFICATION NUMBER: 155139 | A. BUILDING B. WING | 01 | COMPLETED 02/11/2013 |
|--------------------------|--|--------------------------------|--|--|----------------------|
| | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE | |
| | | | | weeks periodically thereafter for correct usage of sign, by Director Nursing and/or designee | of |
| | | | | How will the corrective action be monitored to ensure the deficier practice will not recur i.e., what quality assurance program will be put into place? | nt |
| | | | | *monthly preventive maintenance schedule and CQI "Life Safety Review" tool will be used weekly monthly x 3 and quarterly up to 6 months to monitor so deficient practice does not recur by Maintenance Director. | x 4, |
| | | | | *Maintenance Director is respons for compliance, results will be reported to QA committee | ible |
| | | | | Completion Date: 3-13-13 | |
| | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTFG21

Facility ID: 000064

If continuation sheet Page 25 of 25